

Verification of Mental Health Counselor Supervised Postgraduate Experience

Applicant:

2.

3.

Use a separate form for each supervisor verifying your postgraduate supervision and professional experience for each practice setting. This form may be duplicated. Fill out Section 1 and forward to the supervisor for completion.

Print or Type Clearly:						
Name Last		First		Middle	Birth Date (mr	n/dd/yyyy
Address						
City		State			Zip	
Approved Supervisor: (an apple health practitioner)	proved license	ed mental health _l	oractitioner or	equally qua	llified licensed m	ental
The above individual seeks ve as a mental health counselor.	•		ealth counsel	or postgradi	uate experience	for licens
Supervisor Name				Current Phone		
Credential State				First Issuance Date		
Current Street Address						
ity State					Zip	
Supervised Work Experience least 1,200 of the total hours must be immediate super	Month Supervised to the direct of the direc	n Day d postgraduate ex client counseling v	vith individual	Month sists of a mi s, couples, f	families or group	s. 100
Supervision				Total Hours		
Number of hours in immediate supervision (100 hours required) Number of hours of direct counseling (1200 hours required)						
Number of all other supervised hours						
Number of supervised experie	nce hours (300	00 hours require	d)			
Supervisor I certify that the above informa Department may request addit on this document. I also attest supervisor.	ional informati	on, if it is needed	to evaluate t	he application	on of the individu	al name
Signature: Da						
				Return this t	form to the addre	ss above